

## ORIGINAL ARTICLE



# The Health Status of Latino Immigrant Women in the United States and Future Health Policy Implications of the Affordable Care Act

美国拉美女性移民的健康状况和《平价医疗法案》的未来健康政策含义

El estado de salud de las mujeres inmigrantes latinas en los Estados Unidos y las implicaciones de la Ley de Cuidado de la Salud Asequible para la futura política sanitaria

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## ABSTRACT

Immigrant women of Mexican birth face unique health challenges in the United States. They are at increased risk for developing many preventable health conditions due in part to limited access to healthcare and benefits, legal status, and inadequate income. Increased vulnerability of women has established a growing need to focus on their healthcare needs because of their role, position, and influence in the family.

The purpose of this article is to review factors that impact the health status of Mexican-born women living in the United States and review policy implications of the Affordable Care Act for this population.

Mexican-born women are the largest female immigrant group in the United States. Therefore, they comprise the group that will need health coverage in the greatest proportion. As a result, there will be a need for culturally and linguistically appropriate healthcare services and culturally sensitive providers.

## BACKGROUND

Latino immigrant women, particularly Mexican women, are at increased risk for developing many preventable health conditions.<sup>1-3</sup> This is due in part to limited access to healthcare and benefits, legal status, and limited income.<sup>1,4,5</sup> While Mexican women have traditionally migrated as a result of their families, their immigration is no longer restricted to family reunification. Growing push factors for their migration include securing employment and ensuring the well-being of their children.<sup>1</sup>

Mexican women comprise the largest female immigrant group in the United States, accounting for 5.4 million (47%) of the Mexican immigrant population.<sup>6</sup> In 2008 alone, more than 40% of the female

## 抽象

在美国，墨西哥出生的女性移民面临着独特的健康挑战。她们面临着罹患多种可预防性病症的高风险，部分原因是其所获的医疗护理和福利有限、不合法身份和收入不足。这些女性患病风险增加，加之其所扮演的角色、所处的地位以及对家庭的影响，使得关注其医疗护理需求的呼声越来越高。

本文旨在审查生活在美国的墨西哥出生女性的健康状况影响因素，以及《平价医疗法案》对该人群的政策含义。

墨西哥出生女性是美国境内最大的女性移民群体。因此，她们在需要获得健康保险承保的这一群体中，占有最大的比例。因而也就需要有相应文化和语言方面的医疗护理服务和具有文化敏感性的服务提供者。

## SINOPSIS

Las mujeres inmigrantes originarias de México se enfrentan en los Estados Unidos a problemas sanitarios únicos. Corren un alto riesgo de desarrollar muchas patologías prevenibles,

en parte debido a su acceso limitado a atención y prestaciones sanitarias, a su estatus legal y a sus ingresos insuficientes. La mayor vulnerabilidad de las mujeres ha hecho que cada vez resulte más apremiante que se centren en sus necesidades de atención sanitaria debido a su papel, posición e influencia en la familia.

El objetivo de este artículo es revisar los factores que afectan al estado de salud de las mujeres originarias de México que viven en los Estados Unidos, y las implicaciones en el ámbito de las políticas de la Ley de Cuidado de la Salud Asequible (Affordable Care Act) para esa población.

Las mujeres originarias de México constituyen en los Estados Unidos el colectivo inmigrante femenino más numeroso. Por esa razón, conforman el grupo que necesitará cobertura sanitaria en una proporción más alta. Como resultado, surgirá una necesidad de servicios de asistencia sanitaria que sean adecuados desde el punto de vista cultural y lingüístico, y de proveedores de atención culturalmente sensibles.

immigrant population in 10 US states was from Mexico.<sup>1</sup> These women are more likely to lack legal status, with 59% of the US undocumented population born in Mexico.<sup>7</sup> They also have the lowest level of participation in the formal labor market, limiting them to low-paying jobs with limited access to employer-based health insurance.<sup>6</sup> Increased vulnerability of Mexican immigrants has established a growing need to focus on the health of women because of the role, position, and influence they have in the Hispanic family.

The 2010 Affordable Care Act (ACA) is a crucial piece of health legislation that undoubtedly will increase access to quality healthcare services for Mexican immigrant women who are without employer-sponsored or private

**Table 1** Summary of Main Review Articles With Results

Citation	Objectives	Methods	Results/Conclusion
Leite P et al (2013)	Review of health outcomes of Mexican immigrant women in the United States	The report provides a summary current demographic and socioeconomic status, health coverage and use of health services, the immigrant paradox, positive health outcomes, and the ACA as it pertains to Mexican immigrant women	Increased healthcare coverage for Mexican immigrant women
Guendelman et al (1995)	Study examined whether the nutrient intake of second generation Mexican American women of childbearing age worsens as compared to first generation Mexican American women	Secondary analyses of the 1982-1984 Hispanic Health and Nutrition Examination Survey	First generation Mexican American women had a higher average intake of protein, vitamins A and C, folic acid, and calcium compared to second generation Mexican American and non-Hispanic white women
Perez-Escamilla et al (2011)	Study examined the association between acculturation and health disparities in Latinos with a focus on type 2 diabetes and nutrition-related risk factors	1. Systematic reviews identified through PubMed 2. Backward searches that were based on articles cited 3. Experts in the field 4. Authors' personal files	The majority of evidence supported an association between acculturation, poor dietary quality, and obesity
Meng et al (2012)	Identify cultural and linguistic outreach and enrollment needs of California's diverse communities in order to maximize enrollment in the ACA	Focus groups with low-income racial/ethnic and low English proficiency adults to learn how information about healthcare coverage is obtained, shared, and acted upon	Some racial or ethnic groups were more aware of changes and benefits under the ACA compared to others
Finch et al (2003)	Study examined the effect of social support mechanisms as potential moderators and mediators of the relationship between stressful acculturation experiences and self-ratings of physical health	Data from a sample of Mexican origin adults sampled under a probabilistic, stratified, cluster sampling design in Fresno County, California	Physical health is negatively associated with acculturation stressors and positively associated with social support; discrimination is only associated with poorer physical health among those for whom social support is lacking

Abbreviation: ACA, Affordable Care Act.

health insurance.<sup>4</sup> However, the ACA excludes undocumented immigrants as well as legal immigrants with less than 5 years residence in the US.<sup>4,6,8</sup> It thus places these groups at increased risk of developing chronic diseases that affect minority ethnic groups in particular.<sup>2,3</sup>

The purpose of this article is to review factors that are associated with the health status of Mexican-born women living in the United States and review policy implications of the ACA for this population (Table). In this article, the term *immigrant* refers to Mexican-born women or other immigrant women who are living in the United States, and the term *nonimmigrant* refers to US-born women of Mexican origin or other US-born racial/ethnic groups.

### HEALTH DISPARITIES AMONG MEXICAN IMMIGRANT WOMEN

Mexican-born women are disproportionately impacted by preventable health conditions as compared to other racial/ethnic groups in the United States. For instance, those of Mexican birth are more likely to be overweight or obese (78.5%) compared to non-Hispanic whites (NHWs) (61.3%).<sup>9</sup> Physical inactivity is most prominent among Mexican immigrant females (49%) compared to blacks (45%) and NHW women (28%).<sup>1</sup> Diabetes is more prevalent among Mexican

immigrant women with a longer length of stay in the United States (9.1%) compared to NHW women (5.7%).<sup>1</sup> Also important to note is that the prevalence of diabetes among recently arrived Mexican immigrant women is only 4%.<sup>1</sup> Finally, Mexican-born mothers are less likely to receive prenatal care beginning in the first trimester (62%) compared to other immigrant women (72%) and NHW women (76%).<sup>1</sup>

### THE IMMIGRANT PARADOX AND ACCULTURATION RISK

The immigrant paradox or epidemiologic paradox indicates that first-generation Mexican immigrants experience higher poverty rates, lower education levels, and less access to healthcare than second-generation Mexicans and NHWs but have similar or better health outcomes.<sup>10,11</sup> Since the 1980s, the best substantiated findings supporting the immigrant paradox are the prevalence of low birth weight (LBW) infants and low infant mortality rates among Mexican-born women.<sup>12,13</sup>

These positive health outcomes still hold true today. A recent study indicated that infant mortality rates among Mexican-born women (5.1 per 1000 live births) were lower than that among NHW women (5.3 per 1000 live births).<sup>14</sup> A likely explanation is that less acculturated women are more likely to consume more healthful foods and less alcohol and tobacco compared to more highly

acculturated women, factors that may contribute to more positive birth outcomes.<sup>1</sup> However, as length of stay in the United States increases, some of these behaviors (eg, consumption of an unhealthful diet and physical inactivity) are more likely to mirror the behaviors of NHW women.<sup>15</sup> Such behaviors also may contribute to the high prevalence of obesity and diabetes among Mexican immigrant women.<sup>19</sup> In contrast, high acculturation of Latinos has been positively associated with a higher socioeconomic status and increased access to healthcare.<sup>16,17</sup>

Acculturation risk factors are not limited to smoking, excessive body fat, and high blood sugar concentrations. In fact, acculturation stressors also include discrimination, legal status, and limited English proficiency.<sup>1</sup> The pattern of worse health outcomes in relation to length of time in the United States further strengthens the immigrant paradox while simultaneously making it more complex. Other factors to consider when analyzing the immigrant paradox include the social environment (eg, stress and legal barriers to resources); the physical and occupational environment (eg, pollution, overcrowding, crime, poor housing infrastructure); and the cultural environment (eg, more normative substance use behavior and access, poorer nutritional options).<sup>18</sup> Additional factors that are associated with poor health outcomes among Mexican immigrant women include socioeconomic status.

#### **SOCIOECONOMIC STATUS RISK FACTORS SPECIFIC TO MEXICAN IMMIGRANTS**

Most Mexican-born women are characterized by low educational attainment that negatively impacts their income, socioeconomic integration, and access to healthcare.<sup>1</sup> Although they tend to have completed more years in school than their male counterparts, the majority of Mexican-born women (58%) have less than a high school degree, in comparison to other female immigrants (14%), blacks (12%), and NHWs (6%).<sup>4</sup> There is even a lower proportion of Mexican-born women with a bachelor's or higher degree (8%) compared to the substantially higher degrees achieved by other immigrants (46%), blacks (27%), and NHWs (41%).<sup>1</sup> Low socioeconomic status also is associated with legal status and type of employment.<sup>1</sup>

The contemporary immigration context has made legal status a critical issue for the Latino population in the United States. Current estimates indicate that 8.3 million undocumented immigrants were in the labor force in 2008, a 5.4% share of the total labor force.<sup>7</sup> However, these estimates may not reflect the participation rates of undocumented immigrants in the labor force because of underreporting in surveys and undercalculating in general. Only 58% of working-age women who are undocumented immigrants are in the labor force, well below the percentage of women who are US-born (73%) or legal immigrants (66%).<sup>7</sup> This may be due to the higher percentage of nonworking undocumented immigrant women who are raising children at home (29%) compared to other immigrants (16%) and

US-born women (8%).<sup>7</sup>

With regard to occupation, only 10% of Mexican-born immigrants work in management, professional, and related jobs, compared with 41% of immigrants from other countries.<sup>7</sup> The types of employment that directly affect socioeconomic status and access to healthcare for Latinas are primarily concentrated in low-wage and informal markets.<sup>1</sup> The Great Recession of 2008 may have impacted the types of low-wage industries that remained competitive, such as the construction industry. According to the Pew Hispanic Center, the recession in the construction industry led to a rise in the unemployment rate for Hispanics (6.5%) compared to non-Hispanics (4.7%).<sup>19</sup> Mexican immigrant men have been concentrated in the construction industry,<sup>19</sup> in comparison to immigrant women, the unemployment rate among male spouses may have afforded some Mexican immigrant women to be head-of-household during the Great Recession. Moreover, the high unemployment rates among male spouses impact the entire immigrant household, putting even greater constraints on income for basic needs, including health services.

As many Mexican-born women are in low-wage jobs in the United States, it is very difficult for them to surpass poverty levels. Research indicates that 30% of Mexican-born women are below 100% of the US federal poverty level, compared to 10% of US-born NHW women.<sup>1</sup> Furthermore, about twice as many Mexican-born women are living in poverty in comparison to other foreign-born immigrants (30% vs 14%).<sup>1</sup> Mexican-born women are even more likely to be under 150% of the US federal poverty level, and approximately 58% of them have children under the age of 18, whereas only 20% of US-born NHW women with children are below 150% of the US federal poverty line.<sup>1</sup> Finally, the challenges of Mexican-born women increase when approximately 80% of those between 18 and 64 years of age are below the 150% of poverty line and are also single parents.<sup>1</sup>

#### **FUTURE HEALTH POLICY IMPLICATIONS: THE AFFORDABLE CARE ACT**

With limited access to health services through public programs and with low levels of employer-based coverage, immigrant families traditionally have sought health coverage through community health centers, often with somewhat inadequate services. Many also postpone routine healthcare until they become ill and emergency care is needed. The ACA was passed with the intention of expanding access to the uninsured, thus reducing costs and redirecting services toward prevention and primary care. Currently, among women, Mexican immigrants have the highest un-insurance rate (54.6%) as compared to other immigrants (26.2%), blacks (22.5%), and NHWs (13.9%).<sup>6</sup> Therefore, a large majority of Mexican-born women will have improved access to health services post-ACA implementation. On the other hand, they also will face the greatest rate of exclusion from this generally positive set of health reforms, as undocumented immigrants as well as legal

immigrants with less than 5 years' residence in the United States are excluded from the health law.<sup>4</sup>

While the uninsured will undoubtedly have increased access to healthcare when the ACA takes full effect in January 2014,<sup>20</sup> the landscape of health insurance coverage will demand the efforts of many healthcare advocates to help millions of individuals to navigate a completely new system. Latinos, particularly women of Mexican birth, comprise the group that will need health coverage in the greatest proportion. Given the nature of Mexican immigrant families—characterized by mixed-immigration status, low socioeconomic background, low enrollment in healthcare programs, and limited English proficiency<sup>1</sup>—there will be a need for culturally and linguistically appropriate health services and culturally sensitive healthcare providers. Such services will ensure that the future healthcare needs of this population are met. The ACA has a number of funding provisions in place to address culturally and linguistically appropriate services<sup>4</sup>:

1. Training of culturally competent healthcare providers;
2. Workforce development—an increase in the number of healthcare providers in medically underserved areas and diversifying the workforce; and
3. A more streamlined process and the development of uniform categories for the collection and reporting of data on race/ethnicity and language

These requirements will likely improve the ability for researchers, policymakers, healthcare providers, and advocates to address health disparities. Though empirical research is still somewhat limited, culturally sensitive interventions have been shown to improve service provision and patient satisfaction.<sup>21</sup> Components of cultural competence include employment/retention of culturally competent personnel such as community health workers or *promotoras* and provision of interpreters/language services.<sup>21</sup>

Some research has been conducted prior to implementation of the ACA to investigate the needs of future consumers. A recent study among low-income racial/ethnic diverse and limited English proficient (LEP) adults in California indicated that participants prefer to have bilingual community health workers in order to provide assistance with the ACA enrollment process.<sup>22</sup> The study also identified other barriers such as educating hard-to-reach Latino populations including migrant farmworker women about enrollment and mixed-status immigration families who fear deportation if they enroll an eligible family member.<sup>22</sup> Other core enrollment challenges include technology barriers and addressing literacy skills for low-income families.<sup>22</sup> Funding is available to address these issues and to help individuals enroll in a health insurance plan.<sup>22</sup>

Current research among consumers of the ACA also indicates that enrollment outreach information should include types of health insurance coverage and what services would be provided, qualification for coverage,

costs, reviews about the program, and whether information on healthcare providers who will speak the primary language of the patient will be available.<sup>22</sup> These results are likely to have important policy implications for states with large Latino populations.

Although some immigrants will not qualify to purchase insurance through the health insurance marketplace, other options for healthcare include federally qualified community health centers (FQHCs). The ACA requires funding increases for FQHCs to create new sites in medically underserved areas and expand preventive and primary healthcare services.<sup>4</sup> Approximately 34% of healthcare patients are Latino; therefore, FQHCs will play a vital role in providing care to the newly insured.<sup>2</sup>

## CONCLUSION

The largest female immigrant population in the United States is Mexican. Increased labor demands, better employment opportunities, and family reunification have contributed to their migration. The vulnerability of Mexican immigrant women has established a growing need to focus on their physical and mental health because of the role, position, and influence they hold in the Hispanic family, as well as their impact on future generations. Mexican-born women often are characterized by low educational attainment, which limits their employment opportunities and access to employment-based coverage, negatively impacting their health. Other factors such as high acculturation also have contributed to poorer health outcomes among this group over time. The ACA ideally will increase access to healthcare, thus reducing health disparities among Mexican immigrant women. Finally, research collaborations will be needed to develop binational initiatives so that researchers can better understand the cultural strengths of Mexican women who immigrate to the United States. Such knowledge also is needed to support the health and well-being of this population.

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## BOOK REVIEW

# *Just Be Well: A Book for Seekers of Vibrant Health*

Review by David Riley, MD

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*The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that we individual clinicians acquire through clinical experience and clinical practice.*

—David Sackett, et al, *BMJ*,  
January 1996

When Dr Tom Sult, author of *Just Be Well*, says, "Neither information nor knowledge is adequate; one must have wisdom to make impactful lasting change," he's in good company. David Sackett, OC FRSC, one of the leaders of evidence-based medicine, says much the same. *Just Be Well* is not only informative; once you start to read it, you will have a hard time putting it down. Dr Sult's distinctive style allows his skill as a writer and storyteller, brilliance as a physician, and compassion as a human being to shine through.

In *Just Be Well*, Dr Sult tells a compelling narrative story of his exploration of the foundations of health and illness. He begins by asking the reader a question: "When was the last time you were completely and truly well? I don't mean the last time you 'felt okay' for a day or two; I mean completely well." Using this as the reference point, most of us have probably been suffering for longer than we care to remember and may have lost sight of the fact that "disease is the body doing what it is supposed to do, given its environment."

Dr Sult proceeds to illustrate through a series of case reports what functional medicine—a systems-oriented approach to chronic illnesses—offers patients as they interact with practitioners and make lifestyle choices. He walks the reader through the process that many functional medicine practitioners use as they work with patients to identify and treat the underlying causes of disease.

He clearly and persuasively illustrates the importance of the timeline and the functional medicine matrix. The timeline helps identify the links between key elements of a person's history and genomics, the environment, and his or her lifestyle. The functional medicine matrix organizes isolated symptoms around seven key biological processes or functional systems: assimilation, defense and repair, energy utilization, biotransformation and elimination, transportation, communication, and structural integrity. Realignment a person's system that is out of balance becomes the work of both the physician and the patient. When the therapeutic relationship creates a context and meaning for the patient, health often can be restored.

In *Just Be Well*, Dr Sult does not stand on the pedestal or intellectual authority of his position as a physician. Instead, he candidly reveals his struggles to become a physician as well as his concerns for his patients. This is part of what makes this book so enjoyable to read and why practitioners and patients alike will find it accessible. *Just Be Well* deserves a readership among a wide variety of practitioners and their patients.

